MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Road Pasadena, TX 77504	MDR Tracking No.: M5-04-1485-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX 15 Pacific Employers Insurance Co. ACE USA/ESIS	Date of Injury: Employer's Name: Conoco Phillips Company Insurance Carrier's No.: C290C9239285

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/02/03	04/02/03	**Outpatient Surgery: Shoulder Arthroscopy**	$28,641.18	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The insurance carrier used codes "M, U, & D" to deny payment and the healthcare provider is unable to determine what changes they were applied to. The carrier did not make a fair and reasonable reimbursement and did not make consistent reimbursement. The codes were incorrectly used and the carrier did provide preauthorization for the outpatient surgery.

PART IV: RESPONDENT'S POSITION SUMMARY

The carrier provided preauthorization for a shoulder arthroscopy and neuroplasty. The provider also requested preauthorization for a carpal tunnel release, but there was an unresolved dispute regarding compensability of the wrist problems (the outpatient surgery in this dispute did not include the wrist). The carrier denied most of the services rendered using a "U" code, but with the text description that "(b)ased upon a nurse review, amount appears to be an overcharge and/or excessive for services rendered." Carrier paid a fair and reasonable amount based on an Intracorp nurse review.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The first issue relates to whether this is a medical necessity dispute or a dispute over the amount of reimbursement. Given that the insurance carrier preauthorized the shoulder arthroscopy and the text description used by the carrier on the Explanation of Benefits (EOB), it appears clear that the medical necessity of these services is not a dispute. Accordingly, this dispute will be processed as a fee dispute and does not require the assignment of an Independent Review Organization.

This dispute relates to outpatient surgical services provided in a hospital that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

In this situation, the requestor did not provide any clear information on what a "fair and reasonable" reimbursement should be for these services. The requestor purports that their total charges should be considered the amount for the "fair and reasonable" reimbursement. In addition, the carrier provided extremely limited information on their position regarding what is the "fair and reasonable" reimbursement. Accordingly, we had to consider other sources of information to attempt to determine the appropriate amount due for these outpatient services.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement

ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these types of facilities. In addition, we received information from both Ambulatory Surgical Centers (ASCs) and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

The recommended range for outpatient hospital services was from 148% to 163% of Medicare. In performing a comparison of the Medicare reimbursement for these outpatient services (without including all the various medical payment policies which would reduce the amount), it appears that the insurance carrier has paid more than even the high end of this range. In addition, it appears that the insurance carrier has paid more than what would have been reimbursed to an Ambulatory Surgery Center for similar procedures in a similar type of facility under the current ASC Fee Guidelines.

Given this information and the lack of any documentation to support another amount from either the requestor or the respondent, I find that the fair and reasonable reimbursement amount for these services is $13,225.57, the amount previously paid by the insurance carrier.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Ordered by:

	Allen C. McDonald, Jr.	04/19/2005
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, Mail Stop 35, 7551 Metro Center Dr., Suite 100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____